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AHRQ

Complete Summary

GUIDELINE TITLE

Suspected adnexal masses.

BIBLIOGRAPHIC SOURCE(S)

Bohm-Velez M, Fleischer AC, Andreotti RF, Fishman EK, Horrow MM, Hricak H, Thurmond A, Zelop C, Expert Panel on Women's Imaging. Suspected adnexal masses. [online publication]. Reston (VA): American College of Radiology (ACR); 2005. 10 p. [22 references]

GUIDELINE STATUS

This is the current release of the guideline.

It updates a previously published version: Bohm-Velez M, Mendelson E, Bree R, Finberg H, Fishman EK, Hricak H, Laing F, Sartoris D, Thurmond A, Goldstein S. Suspected adnexal masses. American College of Radiology. ACR Appropriateness Criteria. Radiology. 2000 Jun;215 Suppl:931-8.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
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SCOPE

DISEASE/CONDITION(S)

Adnexal masses

GUIDELINE CATEGORY

Diagnosis
Evaluation

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Oncology
Radiology

INTENDED USERS

Health Plans
Hospitals
Managed Care Organizations
Physicians
Utilization Management

GUIDELINE OBJECTIVE(S)

To evaluate the appropriateness of radiologic examinations for patients with suspected adnexal mass

TARGET POPULATION

Patients with suspected adnexal mass

INTERVENTIONS AND PRACTICES CONSIDERED

1. Pregnancy test
2. Ultrasound (US)
   - Transabdominal (TA)
   - Transvaginal (TV)
   - Color
   - Pulsatility index (PI) and resistive index (RI), Doppler
3. Computed tomography (CT)
4. Magnetic resonance imaging (MRI)
5. X-ray
   - Abdomen, pelvis
   - Colon, barium enema
   - Kidney, intravenous urogram (IVU)
6. CA 125 levels
7. Aspiration, image guided
8. Positron emission tomography (PET)
9. US follow-up at 6 weeks, 12 weeks, 3 months, 6 months, and 12 months

MAJOR OUTCOMES CONSIDERED

Utility of radiologic examinations in differential diagnosis

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed literature searches of peer-reviewed medical journals, and the major applicable articles were identified and collected.

NUMBER OF SOURCE DOCUMENTS

The total number of source documents identified as the result of the literature search is not known.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

One or two topic leaders within a panel assume the responsibility of developing an evidence table for each clinical condition, based on analysis of the current literature. These tables serve as a basis for developing a narrative specific to each clinical condition.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Since data available from existing scientific studies are usually insufficient for meta-analysis, broad-based consensus techniques are needed for reaching agreement in the formulation of the appropriateness criteria. The American College of Radiology (ACR) Appropriateness Criteria panels use a modified Delphi technique to arrive at consensus. Serial surveys are conducted by distributing questionnaires to consolidate expert opinions within each panel. These questionnaires are distributed to the participants along with the evidence table

and narrative as developed by the topic leader(s). Questionnaires are completed by the participants in their own professional setting without influence of the other members. Voting is conducted using a scoring system from 1 to 9, indicating the least to the most appropriate imaging examination or therapeutic procedure. The survey results are collected, tabulated in anonymous fashion, and redistributed after each round. A maximum of three rounds is conducted and opinions are unified to the highest degree possible. Eighty percent agreement is considered a consensus. This modified Delphi technique enables individual, unbiased expression, is economical, easy to understand, and relatively simple to conduct.

If consensus cannot be reached by this Delphi technique, the panel is convened and group consensus techniques are utilized. The strengths and weaknesses of each test or procedure are discussed and consensus reached whenever possible. If "No consensus" appears in the rating column, reasons for this decision are added to the comment sections.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Criteria developed by the Expert Panels are reviewed by the American College of Radiology (ACR) Committee on Appropriateness Criteria.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

ACR Appropriateness Criteria®

Clinical Condition: Suspected Adnexal Mass

Variant 1: Premenopausal female.

Radiologic Exam Procedure	Appropriateness Rating	Comments
Pregnancy Test	9	Pregnancy status is helpful before performing any imaging study.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, pelvis, TA	8	
US, pelvis, TV	8	
US, pelvis, color	6	
US, pelvis, PI and RI, Doppler	6	
CT, pelvis	4	
MRI, pelvis	4	
X-ray, abdomen, pelvis	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 2: Postmenopausal female.

Radiologic Exam Procedure	Appropriateness Rating	Comments
CA 125	9	
US, pelvis, TA	8	
US, pelvis, TV	8	
US, pelvis, color	6	
US, pelvis, PI and RI, Doppler	6	
CT, pelvis	4	
MRI, pelvis	4	
X-ray, abdomen, pelvis	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 3: Premenopausal female with complex or solid mass evaluated by TAS, TVS, or both; positive pregnancy test.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, follow-up, 6 Weeks	5	Ectopic pregnancy must be excluded initially
US, follow-up, 12 Weeks	2	
US, follow-up, 6 Months	2	
US, pelvis, color	4	
US, pelvis, PI and RI, Doppler	2	
Aspiration, image guided	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
CT, pelvis	2	
MRI, pelvis	2	
PET	1	
CA 125	1	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 4: Premenopausal female with complex or solid mass evaluated by TAS, TVS, or both; negative pregnancy test.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, follow-up, 6 Weeks	8	
US, follow-up, 12 Weeks	6	
US, follow-up, 6 Months	2	
US, pelvis, color	6	
US, pelvis, PI and RI, Doppler	6	
X-ray, kidney, intravenous urogram (IVU)	4	
CT, pelvis	4	
MRI, pelvis	4	
CA 125	4	Should be aware that there can be many false positives.
Aspiration, image guided	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 5: Premenopausal female with complex mass evaluated by TVS: not changed in 6 weeks.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, pelvis, color	6	

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, pelvis, PI and RI, Doppler	6	
US, follow-up, 6 Weeks	6	After 6-week interval with no changes, follow-up with surgical exploration.
US, follow-up, 12 Weeks	2	
US, follow-up, 6 Months	2	
US, follow-up, 12 Months	2	
Aspiration, image guided	4	
CT, pelvis	4	Not indicated unless dermoid suspected.
MRI, pelvis	4	
CA 125	4	Follow-up in another 6 weeks would be adequate.
X-ray, abdomen, pelvis	2	Not indicated unless dermoid suspected.
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 6: Postmenopausal female with a simple ovarian cyst >5 cm in diameter by TAS, TVS, or both.

Radiologic Exam Procedure	Appropriateness Rating	Comments

Radiologic Exam Procedure	Appropriateness Rating	Comments
CA 125	6	
US, pelvis, color	6	
US, pelvis, PI and RI, Doppler	5	
Aspiration, ovarian cyst, image guided	4	
US, follow-up, 12 Months	2	
US, follow-up, 6 Months	2	
US, follow-up, 3 Months	2	
US, follow-up, 12 Weeks	2	
US, follow-up, 6 Weeks	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
CT, pelvis	2	
MRI, pelvis	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 7: Postmenopausal female with a simple ovarian cyst 3 to 5 cm in diameter by TAS, TVS, or both.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, follow-up, 12 Months	7	No solid data to support interval of follow-up.
US, follow-up, 6 Months	7	No solid data to support interval of follow-up.
US, follow-up, 3 Months	5	No solid data to support interval of follow-up.
US, follow-up, 6 Weeks	2	No solid data to support interval of follow-up.
CA 125	6	
US, pelvis, color	4	
US, pelvis, PI and RI, Doppler	4	
Aspiration, ovarian cyst, image guided	4	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
CT, pelvis	2	
MRI, pelvis	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 8: Postmenopausal female with a simple ovarian cyst <3 cm in diameter by TAS, TVS, or both.

Radiologic Exam Procedure	Appropriateness Rating	Comments

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, follow-up, 12 Months	7	
US, follow-up, 6 Months	4	
US, follow-up, 3 Months	4	
US, follow-up, 6 Weeks	2	
CA 125	5	
US, pelvis, Color	3	Initial Doppler evaluation could be used for baseline vascularity. If change is detected, it may influence management.
US, pelvis, PI and RI, Doppler	2	Initial Doppler evaluation could be used for baseline vascularity. If change is detected, it may influence management.
Aspiration, ovarian cyst, image guided	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
CT, pelvis	2	
MRI, pelvis	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 9: Postmenopausal female with simple ovarian cyst <5 cm and RI <0.4 or PI <1.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, follow-up, 12 Months	8	
US, follow-up, 6 Months	6	
US, follow-up, 3 Months	2	
US, follow-up, 6 Weeks	2	
CA 125	7	
Aspiration, ovarian cyst, image guided	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
CT, pelvis	2	
MRI, pelvis	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 10: Postmenopausal female with a complex or solid adnexal mass by TAS, TVS, or both.

Radiologic Exam Procedure	Appropriateness Rating	Comments
US, pelvis, color	8	
US, pelvis, PI and RI, Doppler	8	

Radiologic Exam Procedure	Appropriateness Rating	Comments
CA 125	7	
MRI, pelvis	4	Either CT or MRI helpful for staging.
CT, pelvis	3	Either CT or MRI helpful for staging.
Aspiration, ovarian cyst, image guided	2	
US, follow-up, 12 Months	2	
US, follow-up, 6 Months	2	
US, follow-up, 3 Months	2	
US, follow-up, 6 Weeks	2	
X-ray, abdomen, pelvis	2	
X-ray, colon, barium enema	2	
X-ray, kidney, intravenous urogram (IVU)	2	
PET	2	
Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Adnexal masses have a long list of diagnostic possibilities, and US study should be correlated with history and laboratory tests. Morphological analysis of adnexal masses with US can help narrow the differential diagnosis; however, US cannot always distinguish malignant from benign masses with the accuracy sufficient to avert surgery. Transabdominal ultrasound (TAS) and transvaginal ultrasound (TVS) complement each other, and in many facilities, patients are scanned by both techniques.

The applications of TVS in evaluating adnexal masses have been well described. TVS is useful where TA studies are suboptimal in studying obese patients, or for women who have a large amount of intestinal gas or are unable to adequately

distend their bladders. The improved resolution of high-frequency transducers within the vagina increases the diagnostic confidence level in evaluating adnexal masses to about 72% to 78%. TVS can be used not only to differentiate between cystic and solid masses but also to improve characterization of the septations, mural nodules, and echogenicity of cystic and complex ovarian masses by giving additional information on the wall thickness and inner wall. TVS has increased the specificity to 83% for diagnosing ovarian cancer.

In addition, TVS can be used to assess the vascularity of a mass and provide a guide for aspiration of certain masses. However, due to the narrow field of view of the TV probe, TAS is needed to provide an overview of the relationship of the mass to other pelvic structures. TVS also can help determine the origin of the mass. When evaluating pelvic masses, it is important to determine its origin- whether it is ovarian or extraovarian. Masses arising from the ovary can be separated from extraovarian masses by identifying a rim of compressed ovarian parenchyma around the mass, which can form a break sign. Masses arising from the fallopian tube are usually seen as distended fusiform tubular structures in the lateral aspect of the uterine cornua. Masses arising from the uterus are usually solid, and there is no cleavage plane between the mass and the uterus.

TVS can help in characterizing a mass sonographically as cystic, solid, or complex. Cystic masses are usually ovarian or tubal. A simple cystic mass is an anechoic mass with smooth thin walls, no mural nodules or septations, and associated with acoustic enhancement. Identification of a cyst has extremely important implications for subsequent management. Sonographic identification of a simple cystic mass establishes a benign process in 100% of premenopausal women and in 95% of postmenopausal women. There are no solid data to support recommendations for specific follow-up intervals. Cysts in premenopausal females will resolve spontaneously and need not be removed unless torsion or rupture occurs. In postmenopausal women, cysts are seen with a frequency of 17% and are not related to hormonal therapy or time since onset of menopause. Theses cysts may disappear (53%), not change (28%), enlarge (11%), decrease (3%), or increase and decrease (6%). Although adnexal cysts 5 cm or less in postmenopausal females are not considered malignant, a 3 to 5 cm cyst may need to be correlated with CA 125 and Doppler findings. TVS aspiration of simple cysts, done by some, is controversial since either peritoneal contamination by ovarian cancer cells or pseudomyxoma peritonei may result. TVS aspiration plays an important role in diagnosis and treatment of tubovarian abscesses (TOAs) and diagnosis of recurrent ovarian cancer.

Most solid adnexal masses are pedunculated fibroids. Leiomyomas are the most common uterine neoplasms, and 20% to 30% occur in women older than 30 years of age. Pedunculated or subserosal fibroids sometimes can be very difficult to differentiate from solid extraovarian masses.

Solid intraovarian masses include benign ovarian tumors such as cystic teratomas, fibromas, thecomas, malignant ovarian tumors, and ovarian torsion. The most common ovarian neoplasm is benign cystic teratoma, which has a broad spectrum of sonographic appearances. When the diagnosis is in doubt, CT can depict the fat, teeth (7%) or bony fragments (18%). All solid intraovarian masses should be removed surgically. Complex adnexal masses are usually ovarian in origin, and in premenopausal females, most commonly represent hemorrhage cysts or

endometriomas. The sonographic characteristics suggest the diagnosis, and a follow-up US can be done in six weeks to evaluate for resolution. In the appropriate clinical setting, tubovarian abscesses, ectopic pregnancies, and ovarian torsions can present as complex masses; therefore, a pregnancy test is important to narrow the differential diagnosis.

Even though US cannot definitely distinguish malignant from benign neoplasms, it provides useful information. Various authors have devised morphologic scoring systems for pelvic masses to predict ovarian malignancy based on size, internal borders, and presence of septa, papillary projections, and echogenicity. The presence of mural nodules or septations suggests that an adnexal mass is a neoplasm. Three-dimensional sonographic morphologic assessment does not appear to improve the diagnosis of complex adnexal masses.

Color flow and Doppler have been proposed to help distinguish between malignant and benign adnexal masses. The overall accuracy of characterization of benign and malignant masses was 94% for morphologic appearance and 80% with color and duplex Doppler imaging, with no significant difference in sensitivity. One study compared TVS Doppler with TVS findings. However, using a RI cutoff of 0.72 gave a sensitivity of 92.6% and specificity of 52.6%, similar to results obtained with TVS alone. Malignant masses are usually vascular. The low resistant Doppler waveform with PI <1 or RI <0.4 seen in malignant lesions can also be demonstrated in inflammatory masses, vascular benign neoplasms, endometriomas, corpus luteal cysts, and ectopic pregnancies. A positive value of 73% for diagnosing malignant masses with TV color Doppler imaging will result in one out of four masses that are called malignant by US to be benign histologically. High PI or RI suggests benignity; however, malignant tumors may show relatively high impedance flow also. The overlap of these indices in benign and malignant masses limits their clinical usefulness.

The combination of color Doppler with serum CA 125 has been proposed to increase sensitivity for differentiating benign from malignant ovarian tumors. When increasing the cutoff point of CA 125 from 35 U/mL to 65 U/mL in the presence of resistive index <5, the best specificity (100%) and positive predictive value (PPV) (100%) were reached.

The goal of the US examination is not simply evaluation of the adnexal mass, but the ability to combine the ancillary features such as hydronephrosis; ascites; pleural effusions; and liver, peritoneal, or omental metastasis which will help in the diagnosis and overall assessment. In problematic cases, MRI may help to determine the origin of a mass (uterine versus ovarian) and help distinguish benign from malignant with an overall accuracy of 91%. On MRI, identification of vegetations in cystic masses and ascites are the best indicators of malignancy. In addition, MRI increases the confident diagnosis of mature cystic teratoma, and leiomyoma.

CT is not indicated for the differential diagnosis of adnexal masses because of poor soft tissue discrimination, except when identification of fat and calcifications is important to make the diagnosis. In addition, CT involves radiation exposure, which is a disadvantage compared to US and MRI.

The sensitivity and specificity of PET in evaluating suspected adnexal masses in asymptomatic females are 58% and 76%, respectively. However, PET may play a role in women with known history of malignancy who present for evaluation of an adnexal mass.

Abbreviations

- CT, computed tomography
- IVU, intravenous urogram
- MRI, magnetic resonance imaging
- PET, positron emission tomography
- PI, pulsatility index
- RI, resistive index
- TA, transabdominal
- TV, transvaginal
- US, ultrasound

CLINICAL ALGORITHM(S)

Algorithms were not developed from criteria guidelines.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on analysis of the current literature and expert panel consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Selection of appropriate radiologic imaging procedures for the evaluation of patients with suspected adnexal mass

POTENTIAL HARMS

- False positive CA 125 test results
- Transvaginal ultrasound (TVS) aspiration of simple cysts is controversial since either peritoneal contamination by ovarian cancer cells or pseudomyxoma peritonei may result.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

An American College of Radiology (ACR) Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These

criteria are intended to guide radiologists, radiation oncologists, and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those exams generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the U.S. Food and Drug Administration (FDA) have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Bohm-Velez M, Fleischer AC, Andreotti RF, Fishman EK, Horrow MM, Hricak H, Thurmond A, Zelop C, Expert Panel on Women's Imaging. Suspected adnexal masses. [online publication]. Reston (VA): American College of Radiology (ACR); 2005. 10 p. [22 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2005)

GUIDELINE DEVELOPER(S)

American College of Radiology - Medical Specialty Society

SOURCE(S) OF FUNDING

The American College of Radiology (ACR) provided the funding and the resources for these ACR Appropriateness Criteria®.

GUIDELINE COMMITTEE

Committee on Appropriateness Criteria, Expert Panel on Women's Imaging

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Panel Members: Marcela Böhm-Vélez, MD; Arthur C. Fleischer, MD; Rochelle F. Andreotti, MD; Elliot K. Fishman, MD; Mindy M. Horrow, MD; Hedvig Hricak, MD, PhD; Amy Thurmond, MD; Carolyn Zelop, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

It updates a previously published version: Bohm-Velez M, Mendelson E, Bree R, Finberg H, Fishman EK, Hricak H, Laing F, Sartoris D, Thurmond A, Goldstein S. Suspected adnexal masses. American College of Radiology. ACR Appropriateness Criteria. Radiology. 2000 Jun;215 Suppl:931-8.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American College of Radiology (ACR) Web site.

ACR Appropriateness Criteria® Anytime, Anywhere™ (PDA application). Available from the ACR Web site.

Print copies: Available from the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191. Telephone: (703) 648-8900.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- ACR Appropriateness Criteria®. Background and development. Reston (VA): American College of Radiology; 2 p. Electronic copies: Available in Portable Document Format (PDF) from the American College of Radiology (ACR) Web site.

PATIENT RESOURCES

None available

NGC STATUS

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